(3)

No. 92-953

Supreme Court, U.S.
FILED
DEC 22 1992
OFFICE OF THE CLERK

In The Supreme Court Of The United States

OCTOBER TERM, 1992

JOANNE W. COLEMAN,

Petitioner,

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

E. Lewis Kincer, Jr.*
DAVID D. HOPPER
MEZZULLO & MCCANDLISH
Suite 804, 700 Building
700 E. Main Street
Richmond, VA 23219
(804) 782-9250

Counsel for Respondents
*Counsel of Record

LAWYERS PRINTING COMPANY 7th & Franklin Bldg. Richmond, Virginia 23219 (804) 648-3664

66pp

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Court of Appeals erred in finding that common law estoppel was not among the panoply of remedies Congress crafted in the ERISA enforcement scheme?

2. Whether the Court of Appeals erred in finding that a health insurer breached no fiduciary duties imposed by ERISA by acting in compliance with the unambiguous automatic termination provisions of the written plan, which provided that the health insurance policy would terminate automatically if premiums were not paid?

3. Whether the Court of Appeals erred in not finding a health insurer in violation of 29 U.S.C. § 1105(a) where there was no evidence that the insurer had actual knowledge that the sponsoring employer failed to notify its employees that it had not paid their health insurance premiums?

4. Whether the Court of Appeals erred in failing to find that a health insurer has an obligation under ERISA to notify employees of a sponsoring employer that the employer has failed to pay health insurance premiums where the written plan imposes such requirement upon the employer and where the written plan provides for automatic termination if premiums are not paid.

TABLE OF CONTENTS

Questions Presented for Review . . i

Table of Authorities iv

Statement of the Case 2

Statement of Relevant Facts 9

Reasons for Denying the Writ . . . 13

Argument. 15

I. This is Not an Appropriate Case for the Application of Common Law Estoppel. 16

A. Common Law Estoppel is Not Available to Modify an Unambiguous ERISA Plan . 16

B. Coleman Failed to Demonstrate Facts Which Give Rise to Common Law Estoppel 24

1. Nationwide Did Not Misrepresent Coverage at the Time of the Claim . . 25

2. Coleman Did Not Demonstrate Detrimental Reliance 31

II. Neither the Plan Nor ERISA Imposed a Fiduciary Obligation upon Nationwide to Notify all Beneficiaries Before Giving Effect to the Plan's Automatic Termination Provisions 34

A. The Plan Imposed No Fiduciary Obligation Upon the Insurer to Notify All Beneficiaries of the Sponsor's Failure to Pay Premiums Before the Health Insurance Policy's Automatic Termination Provisions Became Effective 34

B. The Legal Theory of the Willett Decision in the Eleventh Circuit was Neither Pled Nor Supported by the Evidence in this Case. . . 40

C. ERISA Imposes No Fiduciary Obligation Upon an Insurer to Notify All Plan Participants of the Sponsor's Failure to Pay Premiums Before a Health Insurance Policy's Automatic Termination Provisions Become Effective 44

CONCLUSION 56

TABLE OF AUTHORITIES

Cases

Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154 (6th Cir. 1988) . 50

Cleary v. Graphic Communications Int'l Union Supplemental Retirement & Disability Fund, 841 F.2d 444 (1st Cir. 1988) . 17

Coleman v. Nationwide Life Ins. Co., 969 F.2d 54 (4th Cir. 1992) 6, 9, 22, 30, 35, 37, 42, 43

Degan v. Ford Motor Co., 869 F.2d 889 (5th Cir. 1989) . 17

Dellacava v. Painters Pension Fund, 851 F.2d 22 (2d Cir. 1988) . . 49

Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C. Cir. 1990) . 52

Heckler v. Community Health Services of Crawford, 467 U.S. 51 (1984) 25

Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155 (3d Cir. 1990) 17, 36

In re White Farm Equipment Co., 788 F.2d 1186 (6th Cir. 1986) . 46

Kane v. Aetna Life Insurance Co., 893 F.2d 1283 (11th Cir.), cert. denied, 111 S. Ct. 232

(1990) 18, 19, 20, 21

Lea v. Republic Airlines, Inc.,
903 F.2d 624 (9th Cir. 1990) . 17

Leigh v. Engle,
727 F.2d 113 (7th Cir. 1984) . 36

Licensed Div. Dist. No. 1
MEBA/NMU v. Defries,
943 F.2d 474
(4th Cir. 1991) 36

Local Union 2134, United Mine
Workers of America v.
Powhatan Fuel,
828 F.2d 710
(11th Cir. 1987) 36, 51

Massachusetts Mutual Life
Ins. Co. v. Russell,
473 U.S. 134 (1985) 14, 23

McNeese v. Health Plan
Marketing, Inc.,
647 F. Supp. 981
(N.D. Ala. 1986) 52

Monson v. Century Mtg. Co.,
739 F.2d 1293
(8th Cir. 1984) 51

Moore v. Metropolitan Life Ins. Co.,
856 F.2d 488 (2d Cir. 1988) . . 17

Nachwalter v. Christie,
805 F.2d 956
(11th Cir. 1986) 17, 18

National Companies Health Benefit Plan v. St. Joseph's Hospital, 929 F.2d 1558 (11th Cir. 1991) 18

Pension Benefit Guaranty Corp. v. Greene, 570 F. Supp. 1483 (W.D. Pa. 1983) 49

Presley v. Blue Cross-Blue Shield, 744 F. Supp. 1051 (N.D. Ala. 1990) 53, 54

Rosen v. Hotel & Restaurant Employees & Bartenders Union, 637 F.2d 592 (3d Cir.), cert. denied, 454 U.S. 898 (1981) 48

Seiman v. Warner-Lambert, Inc., 889 F.2d 1346 (4th Cir. 1989), cert. denied, 111 S. Ct. 43 (1990) . . . 46, 48

Singer v. Black & Decker Corp., 964 F.2d 1449 (4th Cir. 1992) 16

Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters., Inc., 793 F.2d 1456 (5th Cir. 1986) 36

Straub v. Western Union Telegraph Co., 851 F.2d 1262 (10th Cir. 1988) 17

Viggiano v. Shenango China Division of Anchor Hocking Corp., 750 F.2d 276 (3d Cir. 1984) 47

Willett v. Blue Cross & Blue Shield, 953 F.2d 1335 (11th Cir. 1992) 40, 41, 42, 43, 44, 54

United States Code

§ 3, 29 U.S.C. § 1002(16)(A) . . . 38

§ 3, 29 U.S.C. § 1002(16)(B)(i) . . 38

§ 104, 29 U.S.C. § 1024(b)(1) . . . 38

§ 404, 29 U.S.C. § 1104(a) 39

29 U.S.C. § 1102(a)(1) 16

29 U.S.C. § 1102(b)(3) 16

29 U.S.C. § 1105(a) 42

29 U.S.C. § 1132(a)(3) 4

29 U.S.C. § 1132(e)(1) 4

29 U.S.C. § 1162(2)(B) 33

Other Authorities

29 C.F.R. § 2509.75-9. FR-16 (1991) 36

3 J. Pomeroy, Equity Jurisprudence

§ 805 p. 192 25

18 M. Rhodes, Couch Cyclopedia of Insurance Law § 71:40 (Rev. ed. 1983) 20

W. Meyer, Life & Health Insurance Law § 9:16 (1971) 21

IN THE

SUPREME COURT OF THE UNITED STATES

No. 92-953

JOANNE W. COLEMAN,

Petitioner

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

The respondent, Nationwide Life Insurance Company[1] ("Nationwide")

---

[1] Nationwide Life Insurance Company is a wholly owned subsidiary of Nationwide Corporation, Nationwide Mutual Insurance Company and Nationwide Mutual Fire Insurance Company, of Columbus, Ohio.

respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the opinion of the United States Court of Appeals for the Fourth Circuit.

STATEMENT OF THE CASE

I. Course of Proceedings Below.

Beginning with her description of the complaint in the district court, Petitioner Coleman's Statement of the Case contains misstatements of fact which must be brought to the attention of the Court. Contrary to Coleman's description, the complaint contained no allegation that Nationwide "breached the fiduciary duties imposed upon it by [ERISA] by advising [Coleman] that the coverage was in effect at the time of her hospitalization on January 27, 1989." Petition for Writ of

Certiorari, p. 4 (hereinafter "Petition"). Instead, the complaint alleged that Nationwide was administrator of the plan and that Coleman was advised by Nationwide at some time prior to her January 25, 1989 admission that hospitalization for childbirth would be covered by the health plan. Furthermore, the complaint did not plead breach of fiduciary duty at all, and contrary to the representations of the Petition at p. 3, did not seek relief under Sections 404, 405(a) and 405(c) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1104, 1105(a), and 1105(c). Instead, the complaint sought relief for denial of benefits in violation of ERISA §§ 502(a)(3) and 502(e)(1), 29 U.S.C. §§

1132(a)(3) and 1132(e)(1).[2]

Contrary to Coleman's representation to this Court, Nationwide did not answer, and indeed has never argued, that "it intended to assign all disclosure duties under ERISA to the employer so that it, Nationwide, would not be responsible for informing or

---

[2] 29 U.S.C. §1132(a)(3) states: a civil action may be brought . . . by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

29 U.S.C. §1132(e)(1) states: except for actions under (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

misinforming beneficiaries about their benefits." Petition, p. 3. Instead, Nationwide answered that any obligation to pay benefits imposed upon it lapsed or was terminated by the specific terms of the plan or by the failure of the plan sponsor to remit premium payments.

Coleman also misconstrues the opinion of the Fourth Circuit Court of Appeals. That court did not hold that Nationwide was "not responsible for representations that its own agents made to Mrs. Coleman that the policy was in effect." Petition, p. 4. To the contrary, the Court of Appeals reached the only conclusion supported by the record--that Coleman's only communications with Nationwide were a telephone inquiry prior to December 1, 1988, in response to which Nationwide sent Coleman her policy number and a

summary of benefits, and a call between December 1 and the birth of her child in which Coleman inquired regarding whether a tubal ligation was within the policy's scope. Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 56-57 (4th Cir. 1992). The Court of Appeals observed:

> Plaintiff Coleman was pregnant at the time of the Nationwide policy's inception. In response to a telephone inquiry, Coleman received a letter from a Nationwide account representative dated December 1, 1988, which included her policy number as well as a brief summary of group benefits. On December 5, 1988, Coleman was sent an authorization for a two-day hospital stay for her childbirth that she requested from Capp Care, a cost containment organization paid by, but not affiliated with, Nationwide. The authorization letter contained the following disclaimer: "CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO

> SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER."
>
> Coleman claims in her affidavit that she was advised by unnamed Nationwide employees on several occasions after December 1, 1988 that she had coverage. In her deposition, however, Coleman indicated that the only time she spoke to Nationwide personnel between December 1 and the birth of her child was in January 1989 when she was told during a telephone inquiry that a tubal ligation would be covered by the policy. Coleman did contend that she spoke to Capp Care employees on numerous occasions during the same time period regarding her authorization for hospitalization.

Id.

There simply is nothing in the record to support the claim that a Nationwide agent represented that the policy was in effect at the time of Mrs. Coleman's hospitalization, and consequently, nothing in the opinion of

the Court of Appeals regarding Nationwide's responsibility or lack thereof for such a statement.

Furthermore, the Court of Appeals did not hold that Nationwide could "cancel the insurance policy retroactively to the last date of payment in spite of its undisputed assurances to Mrs. Coleman that the coverage was in effect at the time of her hospitalization." Petition, p. 7. No "undisputed assurances" were in the record before the Court of Appeals, and that court found no retroactive cancellation, but rather automatic termination for failure to pay premiums:

> The language of this plan indicating that coverage terminates automatically for failure to pay premiums is unambiguous. Courts are not at liberty to disregard the plain language of a plan in order to

> demand that insurers provide coverage for which no premiums have been--or ever will be--paid.

969 F.2d at 57-58.

The Court of Appeals appropriately based its opinion upon the written plan before it. It held that the plan provided unambiguously for its own automatic termination if premiums remained unpaid at the expiration of a grace period, that the plan imposed no requirement that Nationwide notify all beneficiaries prior to automatic termination, and that estoppel was not available to alter or vary the plan's unambiguous terms.

II. Statement of Relevant Facts.

Coleman's husband was employed by a now-defunct contracting firm, Roofing Concepts, Inc. of Mechanicsville, Virginia ("Roofing Concepts"). On

November 1, 1988, Roofing Concepts applied to Nationwide for group insurance benefits for its employees, and a master policy was issued to it with a November 22, 1988 effective date. Roofing Concepts agreed to fund the group medical insurance coverage with 100% employer contributions. The cover page of the master policy stated, "[Nationwide] will pay benefits under the terms of this policy in consideration of the payment of all premiums as set forth in the Policy" and that "[p]remiums must be paid by the Plan Sponsor in the amounts shown in the Policy." The policy expressly stated that "[i]f all the premium is not paid prior to the expiration of the grace period, the Policy will terminate on the last day of the grace period." The policy, by its terms, would

"continue for as long as premiums are paid or until it is cancelled." Additionally, in its application to Nationwide, Roofing Concepts agreed under the General Conditions section of the application that it would "make all premium payments in accordance with the terms of the policy." In its preliminary application for insurance, Roofing Concepts agreed as plan sponsor to assume notice and recordkeeping responsibilities, and the final policy so provided.

Roofing Concepts made a single deposit of $3,665.63 for issuance of the master policy. However, Nationwide's underwriting department formally calculated the monthly premium due at $3,709.42, which was $43.79 greater than the deposit. Nationwide billed Roofing Concepts for the

additional $43.79 owed for the first month, as well as for the $3,709.42 owed for the next month. Roofing Concepts never paid any premiums.

Based on the unambiguous terms of the group health insurance policy applied for by Roofing Concepts, the policy failed for want of consideration. Therefore, on March 6, 1989, Nationwide cancelled coverage as of the effective date, November 1, 1988, and gave Roofing Concepts written notice that the insuring agreement called for Nationwide's payment of benefits only in consideration of payment of all premiums.[3] Nationwide

---

[3] Roofing Concepts notified Nationwide on February 16, 1989 that it "went out of business" on February 15, 1989 and asked that the insurance policy be cancelled, with full knowledge that no premiums had ever been paid on the policy.

also applied the initial premium deposit against prior claims paid.

Coleman was hospitalized for a childbirth on or about January 25, 1989 and incurred medical expenses. On December 5, 1988, Coleman sought and received an authorization from Capp Care (a cost containment organization used by, but not affiliated with, Nationwide) for a two-day hospital admission for the childbirth. However, by the specific terms of the authorization,

> CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER.

Contrary to the allegations in the Petition for Certiorari, there was no evidence that Mrs. Coleman called

Nationwide a number of times and at all times was told that her coverage was in force as of January 25, 1989.

REASONS FOR DENYING THE WRIT

Mrs. Coleman contends that Nationwide should be estopped to deny coverage under a health insurance policy where her husband's employer never paid the premiums it was contractually obligated to pay. Common law estoppel is widely regarded as not available to alter the unambiguous language of an ERISA-regulated plan, and the decisions on this point are in accord with this Court's opinion in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985). Furthermore, even if common law estoppel were grafted onto the remedies available for a violation of ERISA, the

record in this case would not support application of estoppel principals.

In addition, the opinion of the Court of Appeals for the Fourth Circuit is not in conflict with the decisions of other Courts of Appeal regarding an insurer's duty to notify beneficiaries that a sponsoring employer has not paid premiums prior to giving effect to an automatic termination provision in a health insurance policy. Rather, the Court of Appeals below has carefully considered the language of the plan before it, the facts in the record, and the obligations imposed in such a situation by ERISA, and has reached a decision that is in accord with the plan, the facts, and the law.

ARGUMENT

I. This is Not an Appropriate Case for the Application of Common Law Estoppel

A. Common Law Estoppel is Not Available to Modify an Unambiguous ERISA Plan

Congress has required that "all employee benefit plans must be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Congress has further required that every plan shall "provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. § 1102(b)(3). The great majority of circuit courts which have addressed the issue have held that these statutory provisions constitute a Congressional mandate precluding oral modifications of employee benefit plans. See, eg., Singer v. Black &

Decker Corp., 964 F.2d 1449 (4th Cir. 1992); Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1165 n.10 (3d Cir. 1990); Lea v. Republic Airlines, Inc., 903 F.2d 624, 631 (9th Cir. 1990); Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir. 1989); Cleary v. Graphic Communications Int'l Union Supplemental Retirement & Disability Fund, 841 F.2d 444, 447-48 (1st Cir. 1988); Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 499 (2d Cir. 1988); Straub v. Western Union Telegraph Co., 851 F.2d 1262, 1265 (10th Cir. 1988); Nachwalter v. Christie, 805 F.2d 956, 959-61 (11th Cir. 1986).

Coleman appears to concede in her Petition for Certiorari that estoppel is unavailable to alter or vary the written terms of an ERISA plan. Instead, Coleman seems to argue that

estoppel should be available if the purported misrepresentation does not rise to the level of an "outright modification." Petition at 33. Coleman argues based upon a series of Eleventh Circuit cases that estoppel may be applied to hold a party to a particular interpretation of an ambiguous plan term. See Petition at 33 (citing National Companies Health Benefit Plan v. St. Joseph's Hospital, 929 F.2d 1558 (11th Cir. 1991); Kane v. Aetna Life Insurance Co., 893 F.2d 1283 (11th Cir.), cert. denied, 111 S. Ct. 232 (1990)). These decisions are inapplicable to the facts of the present case and do not contradict the general proposition that estoppel claims are preempted by ERISA. Indeed, Coleman's authorities reaffirmed the holding of Nachwalter, 805 F.2d 956,

that "equitable estoppel is not available to plaintiffs in cases involving oral amendments to or modification of employee plans governed by ERISA . . . ." Kane, 893 F.2d at 1285.

In Kane, the issue involved the interpretation of when a "formal process of adoption" must commence, in order to trigger the coverage provisions of a health insurance plan. Two duly authorized representatives of Aetna had interpreted the plan to provide coverage for an infant the plaintiffs were considering adopting, even though the infant's lengthy hospitalization commenced prior to adoption proceedings. Aetna later denied the claim on the ground that where no "formal process of adoption" had been commenced until after the

infant's hospitalization began, there was no coverage for that hospitalization. The Kane court held that because the plan at issue was ambiguous, Aetna would be estopped to deny oral interpretations of the plan made by its duly authorized representatives. Kane, 893 F.2d at 1286.

The Kane court was careful to explain that its ruling was not in violation of the common law prohibition against creating coverage by estoppel:

> We are not unmindful of the rule that estoppel may not be invoked to enlarge or extend the coverage specified in a contract. See 18 M. Rhodes, Couch Cyclopedia of Insurance Law § 71:40 (Rev. ed. 1983) ("The doctrine of waiver or estoppel cannot be given the effect of enlarging or extending the coverage as defined in the contract, nor can it create a contract of insurance, since a cause of action cannot be based on a

> waiver"); cf. W. Meyer, Life & Health Insurance Law § 9:16 (1971) ("The majority rule has been said to be that while waiver or estoppel may operate to avoid a forfeiture of a policy, it can't change or enlarge the coverage").
>
> This rule embodies the concept that estoppel may not be used to create contractual liability where no contract originally existed.

Kane, 893 F.2d at 1285 n.3.

The record below is utterly devoid of any interpretations by Nationwide of the termination provisions of the policy or of the policy's requirement that premiums be paid before the policy is effective. The policy does not contain ambiguous language regarding termination or payment of premiums. Coleman does not seek to use alleged oral representations to construe some ambiguity in the plan, regarding which Nationwide proffered an explanation and

upon which she detrimentally relied. Rather, Coleman seeks to create coverage that the plain language of the plan would deny. The very authority upon which Coleman relies rejects such an argument.

As the Fourth Circuit Court of Appeals observed:

> In this case, estopping Nationwide from terminating the contract of insurance when no premiums were paid would have the effect of providing Coleman benefits even though the contract of insurance unambiguously indicates that she was entitled to none. We can only regard such a result as a modification of the plan's termination provision and, therefore, as being in direct conflict with the statutory requirements.

Coleman, 969 F.2d at 59.

Varying the terms of an ERISA plan by introducing principles of common law estoppel is precisely the sort of tampering with ERISA's intricate

remedial scheme that this Court cautioned against in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985). Section 502 of ERISA sets forth "six carefully integrated civil enforcement provisions." Massachusetts Mutual, 473 U.S. at 146. Common law estoppel is not included in those provisions. To allow Coleman to vary the terms of the written plan in this case by involving principles of estoppel would fly in the face of the expressed reluctance of the United States Supreme Court to tamper with ERISA's remedial scheme.

Under ERISA, a beneficiary is left to the remedies, if any, provided by the plan. The plan in the instant case was the sought-after group health insurance policy. By its own terms, that policy of group health insurance--

if indeed it ever came into existence--expired prior to the time the plaintiff's claim arose. Those terms of the policy are clear. The terms may not be varied by principles of common law estoppel.

B. Coleman Failed to Demonstrate Facts Which Give Rise to Common Law Estoppel.

Coleman claims that actions and statements of Nationwide and its agents preclude Nationwide from denying coverage for her medical expenses. However, even were estoppel available, Coleman failed to meet her burden of establishing an estoppel.

To raise an estoppel, a party must establish a misrepresentation of fact made by the party sought to be estopped, and the "party claiming estoppel must have relied on the

adversary's conduct in such a manner as to change his position for the worse." Heckler v. Community Health Services of Crawford, 467 U.S. 51, 59 (1984) (quoting 3 J. Pomeroy, Equity Jurisprudence § 805 p. 192). Coleman failed to demonstrate either a misstatement by Nationwide or her own detrimental reliance.

1. Nationwide Did Not Misrepresent Coverage at the Time of the Claim

Coleman's Petition for Certiorari, like her briefs below, contains inaccurate and unsupported statements regarding representations allegedly made by Nationwide's agents to Coleman regarding her coverage.

For example, Coleman makes the unsupported statement that she "called Nationwide a number of times [after December 5, 1988] to verify her

coverage. At all times, Nationwide employees told her that her coverage was in force as of January 25, 1989." Petition at 11. Later, Coleman claims, without basis, "[Nationwide] told Mrs. Coleman that medical coverage was in force--even through it knew the sponsoring employer was delinquent in its premium payments." Petition at 35. Coleman also makes the incredible claim that the alleged representations that coverage was in effect at the time of the birth were "undisputed." Petition at 7. The only possible support for Coleman's sweeping statements is the conclusory affidavit submitted in support of her motion for summary judgment.

Coleman's sworn deposition testimony was more detailed regarding her communications with Nationwide and

others than the vague assertions of her affidavit. In her deposition, Coleman testified that she contacted the local Nationwide office in November 1988 to inquire about the new health plan's coverage of her pregnancy as a pre-existing condition. Coleman testified that she received a letter from Nationwide and a summary of group benefits around the first of December 1988, followed by receipt of her group identification card approximately two weeks later. Coleman testified that in early December 1988, she called Capp Care for authorization for hospitalization for childbirth. Although she states in ¶ 10 of her affidavit that she received a letter from Capp Care approving her hospitalization, in her deposition she denied receiving such correspondence.

Coleman testified that at some unspecified time she called Nationwide to inquire if the policy covered tubal ligation, and that on January 23, 1989, she again called Capp Care and was authorized for hospitalization for childbirth at Chippenham Hospital, after speaking with "Alice". She never subsequently spoke with anyone at Nationwide or Capp Care until after receiving the March 27, 1989 letter from Nationwide advising her that the health insurance was cancelled effective November 1, 1988. According to the evidence adduced by Nationwide below, there were no communications concerning coverage between Nationwide and Mrs. Coleman between late November 1988 and late March 1989.

As of the time Coleman talked with Cheryl Reincke in November 1988,

Roofing Concepts had contracted with Nationwide to provide health insurance coverage for its employees and had tendered a deposit towards payment for the first month's coverage. Neither Nationwide nor Reinecke had any factual basis for suspecting that Roofing Concepts would not pay the remainder of the premium due or would terminate the insurance by failing to pay any additional premiums whatsoever.

Coleman's conversations with Capp Care are insufficient to bind Nationwide. By the explicit terms of Capp Care's authorization approval of December 5, 1988,

> CAPP CARE'S AUTHORIZATION OF ADMISSION, CONTINUED STAY, OR SURGICAL PROCEDURE DOES NOT GUARANTEE PAYMENT. PAYMENT IS ALSO SUBJECT TO ELIGIBILITY AND COVERAGE AT THE TIME SERVICES ARE RENDERED AND MUST BE VERIFIED BY THE EMPLOYER OR INSURANCE CARRIER.

Capp Care was only a health review and utilization organization under contract with Nationwide to evaluate and approve medical procedures or length of hospitalizations for such procedures within their realm of expertise. Capp Care did not guarantee coverage or payment of Coleman's expenses. It could only act to authorize Coleman's hospitalization for two days for a routine childbirth, subject to coverage at the time the services were performed. See Coleman v. Nationwide, 969 F.2d at 60 n.2.

Coleman's affidavit is wholly inadequate to create any estoppel against Nationwide. When Nationwide advised Coleman in November 1988 of basic coverage benefits, such representations were of necessity made

consistent with the written terms and conditions of the master certificate of insurance issued to Roofing Concepts and subject to the payment of all premiums by Roofing Concepts. The health coverage offered its employees was always subject to termination and "will continue for as long as premiums are paid." Coleman's vague and conclusory allegations are insufficient to demonstrate any estoppel against Nationwide, and the evidence adduced on cross-motions for summary judgment demonstrates that no estoppel was possible.

2. Coleman Did Not Demonstrate Detrimental Reliance

Even if Coleman had been able to show a material misrepresentation, her hypothetical estoppel claim would fail for lack of proof that she relied on

the misrepresentation. Coleman had not had insurance with her own employer since the beginning of 1986. She was insured under her husband's policy with Aetna Insurance Company for the four years prior to 1988. In October 1988, she received a notice from Aetna that it would no longer provide coverage. She was then six or seven months pregnant. While Mrs. Coleman could have picked up emergency coverage with her own employer's group, such coverage would not have paid for the pre-existing condition--her third-trimester pregnancy. It is, however, the cost of treatment for this condition that Coleman seeks to recover.

Contrary to Coleman's argument that she had a right under ERISA to continuation of coverage that was

frustrated by Nationwide, ERISA does not require continuation of coverage if the employer ceases the group health plan. 29 U.S.C. § 1162(2)(B). Furthermore, the Nationwide policy had no option for conversion to an individual policy once the group policy terminated. Thus, the policy provides "conversion plans are available . . . if coverage ends for any reason other than the termination of this policy."

Coleman's unfortunate situation resulted from Roofing Concepts' failure to make premium payments. Nationwide did nothing to cause the plaintiff to change her situation for the worse. Coleman had no coverage for the pre-existing condition, and her own testimony was that she could not have obtained coverage for that condition. Consequently, nothing that Nationwide

did or failed to do could have caused Coleman to forego securing coverage for her pregnancy.

Thus, Coleman can demonstrate nothing she would have done or refrained from doing in reliance on anything Nationwide or even Capp Care told her or failed to tell her. Consequently, even were recovery on an estoppel theory possible under ERISA, Coleman has failed to demonstrate reliance--an essential element of estoppel.

II. Neither the Plan Nor ERISA Imposed a Fiduciary Obligation upon Nationwide to Notify all Beneficiaries Before Giving Effect to the Plan's Automatic Termination Provisions

A. The Plan Imposed No Fiduciary Obligation Upon the Insurer to Notify All Beneficiaries of the Sponsor's Failure to Pay Premiums Before the Health Insurance Policy's Automatic Termination Provisions Became Effective

Coleman's argument that Nationwide's alleged fiduciary duties required it to notify all beneficiaries that Roofing Concepts had jeopardized their coverage utterly ignores the plan document. Furthermore, the Court of Appeals' decision regarding Nationwide's obligations is not in conflict with ERISA or other precedent applying that legislation.

The Court of Appeals below correctly observed that "before one can conclude that a fiduciary duty has been violated, it must be established that the party charged with the breach meets the statutory definition of "fiduciary." Coleman, 969 F.2d at 61. The Court of Appeals further noted that fiduciary status is not "an all-or-nothing concept," but rather "a court

must ask whether a person is a fiduciary with respect to a particular activity at issue." Id. (citing 29 C.F.R. §2509.75-9. FR-16 (1991); Licensed Div. Dist. No. 1 MEBA/NMU v. Defries, 943 F.2d 474, 477-78 (4th Cir. 1991); Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1158 (3d Cir. 1990); Local Union 2134, United Mine Workers of America v. Powhatan Fuel, Inc., 828 F.2d 710, 714 (11th Cir. 1987); Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.,Inc., 793 F.2d 1456, 1459-60 (5th Cir. 1986); Leigh v. Engle, 727 F.2d 113, 133 (7th Cir. 1984)).

The Nationwide policy in question explicitly imposed upon Roofing Concepts the duty to notify:

> Indeed, Nationwide is not directed by the plan to provide notice to all beneficiaries

> under any circumstances. To the extent that the relevant documents make an allocation of a duty to provide notification of major changes of events, that duty plainly rests with Roofing Concepts. In its preliminary application for insurance, Roofing Concepts agreed as plan sponsor to assume notice and recordkeeping responsibilities in accordance with the terms of the policy. Consistent with this view, the final policy also assigned notice and recordkeeping responsibilities to Roofing Concepts, including the obligation to keep complete records with regard to each person's insurance, to distribute to each eligible employee information regarding the program, and to report changes in eligibility status to Nationwide.

Coleman, 969 F.2d at 61.

Coleman's argument not only ignores the plan documents, but confuses the duties imposed upon plan sponsors and administrators with those of a third party insurer. Nationwide was never designated as an administrator of the

welfare benefit plan. ERISA defines a plan administrator as:

> The person specifically so designated by (i) the terms of the instrument under which the plan is operated; (ii) if an administrator is not so designated, the plan sponsor . . . .

§ 3, 29 U.S.C. § 1002(16)(A). ERISA additionally requires that

> [t]he administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modifications and changes referred to in Section 1022(a)(1) of this title . . . .

§ 104, 29 U.S.C. § 1024(b)(1). A "plan sponsor" is defined as "the employer in the case of an employee benefit plan established or maintained by a single employer." ERISA § 3, 29 U.S.C. § 1002(16)(B)(i). Based on the foregoing provisions, and the law of the case, it is clear that Nationwide was neither

the plan sponsor nor the plan administrator and that Roofing Concepts was.

Nationwide had the obligation, when exercising discretion over the benefit plan, to discharge its duties for the sole benefit of plan participants and beneficiaries "in accordance with the documents and instruments governing the plan . . . ." ERISA § 404, 29 U.S.C. § 1104(a) (emphasis added). These documents required that all premiums be paid by the plan sponsor in consideration for payment of benefits and that the plan would terminate if the premiums were not paid. The premiums were not paid and the plan was terminated. Nationwide was not the plan administrator or plan sponsor and had no duties under ERISA or otherwise to notify Coleman of the termination

for non-payment of premiums or of the employer's discontinuance of the plan.

B. The Legal Theory of the Willett Decision in the Eleventh Circuit was Neither Pled Nor Supported by the Evidence in this Case.

The decision of the United States Court of Appeals for the Fourth Circuit in the instant case is not in conflict with Willett v. Blue Cross & Blue Shield, 953 F.2d 1335 (11th Cir. 1992). Coleman's argument that the result of the Willett case should be the result in this case at least acknowledges the distribution of notification responsibilities made by ERISA and the plan before the Court. However, Coleman's argument ignores the facts before the Court.

In the Willett case, the plaintiffs' employer, Mays, defaulted in its premium payments in November

1987 and at that time entered into negotiations with Blue Cross regarding the payment of premiums. Those negotiations continued until February 1988 when Mays tendered Blue Cross a check for one-half the overdue premiums. Mays laid off its work force in March 1988, and shortly thereafter Blue Cross returned the February check and cancelled the health insurance as of November 1987. Mays, not Blue Cross, ultimately notified the employees of the failure to pay premiums. The plaintiffs each had contact with Blue Cross during the period from November to March and had received assurances of coverage. 953 F.2d at 1338-39.

On these facts, the Court of Appeals for the Eleventh Circuit held Blue Cross might be liable as a co-

fiduciary pursuant to 29 U.S.C. § 1105(a) if upon remand the plaintiffs could establish that Blue Cross had actual knowledge of Mays' failure to notify its employees of Mays' breach of fiduciary duties and that Blue Cross then failed to take reasonable steps to remedy Mays' breach, or that Blue Cross knowingly concealed Mays' breach of duty. Id. at 1342.

In the Coleman case, the record contains no basis for a finding that Nationwide had actual knowledge or knowingly concealed the fact that Roofing Concepts had failed to meet its fiduciary obligation to let its twenty-two employees know it had not made premium payments. In Willett, some 14 months passed from the time the employer defaulted and Blue Cross cancelled the health insurance. In

Coleman, less than three months had elapsed from the expiration of the grace period. In Willett, Blue Cross immediately entered into prolonged negotiations with the employer regarding the overdue premiums. There was no allegation, or evidence of negotiations or contact between Roofing Concepts and Nationwide. In Willett, Blue Cross had direct contact with a number of employees during the 14-month period of negotiations. In this case, the record shows a contact between Nationwide and Mrs. Coleman before the expiration of the grace period, and according to Mrs. Coleman, a telephone call at some unspecified time regarding coverage for a tubal ligation.

There was never any claim in this litigation prior to the motion for reconsideration in the Court of Appeals

that Nationwide had actual knowledge that Roofing Concepts had failed to inform its employees that it had not paid insurance premiums or that, having that knowledge, it failed to take reasonable steps to remedy Roofing Concepts' breach. There is no basis in the record for the allegation made before this Court that Nationwide had actual knowledge of Roofing Concepts' breach and cast a blind eye toward that breach. Accordingly, the decision of the Court of Appeals below is not in conflict with the decision in Willett v. Blue Cross, 953 F.2d 1335.

C. ERISA Imposes No Fiduciary Obligation Upon an Insurer to Notify All Plan Participants of the Sponsor's Failure to Pay Premiums Before a Health Insurance Policy's Automatic Termination Provisions Become Effective.

Implicit in Mrs. Coleman's argument

is the assumption that Nationwide could not cease to provide coverage, regardless of the plan documents and regardless of Roofing Concepts' breach of its contractual obligations, unless and until she could secure alternative coverage for her pre-existing condition. Also implicit in Mrs. Coleman's argument is her position that Roofing Concepts could not alter, amend, or terminate its health insurance policy without affording her notice and time to secure alternative insurance.

Coleman also argues that the decision of the Court of Appeals below conflicts with a purported line of authority she contends imposes an absolute fiduciary duty "to notify beneficiaries of circumstances that jeopardize their coverage," presumably

so that beneficiaries can take action to ensure the continuation of coverage. While there are circumstances in which certain fiduciaries have obligations to provide certain types of information to beneficiaries so that they may protect their rights, there is no line of authority, and no statutory provision within ERISA, requiring insurers in circumstances such as those before the Court to notify beneficiaries of the employer's failure to pay premiums.

It is widely recognized that an employer may unilaterally amend or eliminate unfunded contingent benefits without violating fiduciary obligations under ERISA. Sejman v. Warner-Lambert, Inc., 889 F.2d 1346 (4th Cir. 1989), cert. denied, 111 S. Ct. 43 (1990); In re White Farm Equipment Co., 788 F.2d

1186, 1193 (6th Cir. 1986); Viggiano v. Shenango China Division of Anchor Hocking Corp., 750 F.2d 276, 279 (3d Cir. 1984). The decision to discontinue or amend a welfare benefit plan is a business decision not governed by ERISA fiduciary obligations. "Business decisions, including corporate actions by plan administrators reducing the amount of unaccrued benefits, have routinely been held to be non-fiduciary." Seiman, 889 F.2d at 1349.

The decision of a third-party insurer to give effect to an automatic termination provision in a health insurance policy is likewise a business decision not governed by ERISA fiduciary obligations. None of the cases cited by Coleman imposed such fiduciary obligations. None of the

cases relied on by Coleman involved a business decision of a health insurer who was not the plan administrator to terminate the entire plan because the plan sponsor had failed to pay the initial full premium. All of the cases involved ongoing plans, with specifically imposed ongoing fiduciary obligations to provide notification or not affirmatively to mislead.

Several of the cases cited by Coleman involve pension plans, not welfare benefit plans. Such pension cases involve vested rights and remedies that may not be terminated, as may welfare benefits. See Sejman, 889 F.2d at 1348. Thus, in Rosen v. Hotel & Restaurant Employees & Bartenders Union, 637 F.2d 592 (3d Cir.), cert. denied, 454 U.S. 898 (1981), the court held that the trustee of a union

pension plan fund had a duty to advise an employee of his employer's failure to contribute to the fund, and to take action against the employer to coerce the contribution. Id. at 600. Pension Benefit Guaranty Corp. v. Greene, 570 F. Supp. 1483 (W.D. Pa. 1983) involved a pension plan administered by the employer-sponsor. The same individuals were the trustees of this pension plan and the controlling officers of the sponsor. These fiduciaries had an obligation to disclose their failure to make required pension contributions. Dellacava v. Painters Pension Fund, 851 F.2d 22 (2d Cir. 1988) involved whether a painter had worked less than 35 days in 1969, thus forfeiting all years of work credited before 1972 and, incidental to this determination, whether the trustees of the union

pension fund had a duty prior to 1976 to inform the painter of an employer's failure to contribute.

Other cases relied on by Coleman involve outright misrepresentations or frauds by fiduciaries, in no way similar to the facts before the Court. In Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154 (6th Cir. 1988), the plaintiffs alleged that their employer, a fiduciary under an ongoing plan, misrepresented that it was giving serious consideration to implementing a second offering of severance plan benefits for early retirees, in order to convince employees considering early retirement not to delay their decision in the hope of taking advantage of the second offering. While observing that a business decision to offer a severance plan to encourage retirement

was a non-fiduciary business decision, the court held that such a false communication to a beneficiary may constitute a breach of fiduciary duty. Id. at 1163-64.

Local Union 2134, United Mine Workers of America v. Powhatan Fuel, 828 F.2d 710 (11th Cir. 1987) addressed the issue of whether the president of a bankrupt corporation, as administrator of its health insurance plan, had a duty to act in the best interest of plan beneficiaries by paying health insurance premiums rather than other business expenses. The case also considered whether the president of the employer, as health plan administrator, had a duty not to misrepresent whether employees' insurance was in force.

In Monson v. Century Mtg. Co., 739 F.2d 1293 (8th Cir. 1984), the court

upheld a finding of liability against a corporation and its owner and several corporate officers where the defendant had either fraudulently misrepresented to over 600 employees the amount of the corporation's contribution to its pension fund or had known of the fraud and failed to take action to remedy it.

Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C. Cir. 1990) involved an ongoing health plan in which the insurer misrepresented to an AIDS patient his right to convert to an individual policy upon termination of the group plan. Plaintiff alleged that this misrepresentation, made while the group plan was in effect, caused him not to exercise his right to convert to an individual policy. Id. at 748-49.

In McNeese v. Health Plan Marketing, Inc., 647 F. Supp. 981 (N.D.

Ala. 1986) HPM, unlike Nationwide, was designated by the plan documents as the plan administrator, with full obligations to provide information and with primary control over all aspects of the plan. The employer failed to fund an uninsured plan for over two years, and HPM had full knowledge from the start that the plan was not being funded.

In contrast to the cases cited by the petitioner, Mrs. Coleman's situation is similar to that of the plaintiff in Presley v. Blue Cross-Blue Shield, 744 F. Supp. 1051 (N.D. Ala. 1990). Mrs. Presley's employer maintained a health insurance plan with Blue Cross-Blue Shield. Mrs. Presley became eligible for coverage, filed an application, and received an insurance card, but her employer never paid her

premium to the insurer. As in the instant case, coverage commenced only upon payment of the premium. Id. at 1054. Blue Cross provided notice of the delinquency only to Mrs. Presley's employer, not to Mrs. Presley directly. Like the Willett court, the court in Presley held Blue Cross had no obligation to notify the employee unless Blue Cross had actual knowledge that the employer failed to notify, or unless Blue Cross participated knowingly in the employer's failure to notify. Id. at 1058.

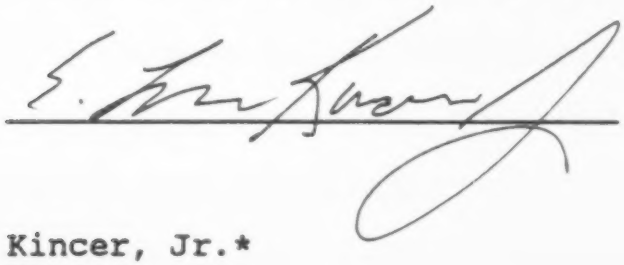
In the present case, unlike the Presley case, there was no ongoing plan. The insurer's action related not to one participant whose premium payment was not received but to the plan sponsor's repudiation of the

entire plan. Nationwide's decision regarding the cancellation of the insurance according to the terms of the policy was a business decision regarding the termination of a welfare plan, not a fiduciary decision regarding the status of a beneficiary's claim. Nationwide had no obligation under ERISA and the case law interpreting it to provide notice to the sponsor's employees and their dependents.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

NATIONWIDE LIFE INSURANCE CO.



E. Lewis Kincer, Jr.*
David D. Hopper
Mezzullo & McCandlish
Suite 804, 700 Building
700 E. Main Street
Richmond, VA 23219
(804) 782-9250

*Counsel of Record

FILING AND MAILING CERTIFICATE

I hereby certify that on this 22nd day of December, 1992, I filed 40 copies of a Brief in Opposition to the Petition for Writ of Certiorari with the Clerk's Office of the Supreme Court of the United States via certified mail.

The necessary filing and mailing was performed in accordance with the instructions given me by counsel in this case.

Barbara E. Dove

Lawyers Printing Company
Suite B-115
7th & Franklin Building
Richmond, Virginia 23219